State/Territory: TENNESSEE

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

/X/ Provided: /_/ No limitations /X/With limitations*

/_/ Not provided.

b. Services of Christian Science nurses.

/_/ Provided: /_/ No limitations /_/With limitations*

/X/ Not provided.

c. Care and services provided in Christian Science sanitoria.

/X/ Provided: /_/ No limitations /x/With limitations*

/_/ Not provided.

d. Nursing facility services for patients under 21 years of age.

/X/ Provided: /_/ No limitations /x/With limitations*

/_/ Not provided.

e. Emergency hospital services.

/X/ Provided: /_/ No limitations /X/With limitations*

/_/ Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

/_/ Provided: /_/ No limitations /_/With limitations*

/X/ Not provided.

*Description provided on attachment.

State: TENNESSEE

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

________ provided   X not provided

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

1. Inpatient hospital services other than those provided in an institution for mental diseases.

   Except for the organ transplants listed below, inpatient hospital days shall be covered as medically necessary. The following organ transplants are limited to the number of inpatient hospital days listed below.

	Transplant Procedure	Total Allowable Days Per Transplant
a.	Heart transplants	43 days
b.	Liver transplants	67 days
c.	Bone Marrow transplants	40 days

   Exceptions to the above list of transplants may be made for other non-experimental transplants if it is found to be medically necessary and cost effective as determined by Medicaid. The allowable inpatient days will be the average length of stay for that transplant.

   Any hospital days paid by insurance or other third party benefits will be considered to be days paid by the Medicaid program. Friday and Saturday admissions will be limited to emergencies or surgery the same or next day.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

2. Outpatient hospital services

   Limited to 30 visits per fiscal year

3. Other laboratory and X-ray services

   Limited to service provided on 30 occasions per fiscal year. An occasion is interpreted to mean laboratory and/or X-ray services performed during a recipient visit, e.g., to a radiologist; or to procedures, e.g., laboratory tests performed for a recipient on a given day by an independent laboratory.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF
MEDICAL CARE AND SERVICES PROVIDED

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Nursing facility services to include Level I and Level II (other than services in an institution for mental diseases) will be covered. Medicaid will apply medical criteria for admission and continued stay at the level of care designated and approved by the Tennessee Medicaid program.

The recipient on Level I Care must require on a daily basis, 24 hours a day, licensed nursing services which as a practical matter can only be provided on an inpatient basis.

The recipient on Level II Care must require on a daily basis, 24 hours a day, skilled/complex nursing or skilled/complex rehabilitative services which as a practical matter can only be provided on an inpatient basis.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

4.b. Early and periodic screening and diagnosis of individuals under 21 years of age, and treatment of conditions found.

(1) Screening services are limited to individuals who are under 21 years of age, and limitations of those services.

(a) EPSDT screenings are provided at intervals which meet reasonable standards of medical practice, as approved by the Tennessee Chapter of the American Academy of Pediatrics.

(b) Screening services must include those components as set out in section 1905(r)(1)(b). Interperiodic screenings will be covered when medically necessary to determine the existence of certain physical or mental illnesses or conditions.

(c) Appropriate laboratory tests and immunizations are covered as described in the Tennessee Medicaid EPSDT Manual (laboratory tests, section 304.2 and immunizations, section 305).

(2) Vision Services

(a) The following is the Tennessee Medicaid approved schedule for vision screening examinations:

Age	Number of Visits
0 through 2 years	3
3 through 11 years	9
12 through 20 years	9

TN No. 90-7A DATE/RECEIPT 6/26/91
SUPERSEDES DATE/APPROVED 9-23-91
TN No. 88-19 DATE/EFFECTIVE 4-1-90

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

4.b. continued

(b) The following vision services are covered for eligible Medicaid recipients under 21 years of age, and limitation of those services includes:

1. one eye examination and refraction per recipient, per fiscal year is covered. Additional screening examinations are covered based on medical necessity.
2. one permanent pair of eyeglasses per recipient, per fiscal year is covered.
3. one dispensing fee per recipient, per fiscal year is covered for Ophthalmologists, Optometrists and Opticians.
4. optical labs can only be reimbursed for the lenses and frames; a dispensing fee is not allowed.
5. one replacement lens and frames for eyeglasses if the original pair are lost, broken or damaged beyond repair, or are no longer usable due to a change in the recipient's vision so that a new prescription is required.
6. one replacement dispensing fee for Ophthalmologists, Optometrists and Opticians.
7. diagnosis and treatment of amblyopia is covered only for recipients 8 years of age and under.
8. orthoptic training, eye exercise is not covered by Medicaid.

(c) Those vision services requiring prior approval are listed in the Tennessee EPSDT Vision Manual, section 304.

(3) Speech and/or hearing services are covered for eligible Medicaid recipients only through speech and hearing centers approved by the Tennessee Department of Health and Environment.

(a) The following is the Tenessee Medicaid approved schedule for speech and/or hearing examinations:

TN No. 90-7A DATE/RECEIPT 6/26/91
SUPERSEDES DATE/APPROVED 9/23/91
TN No. 87-28 DATE/EFFECTIVE 4/1/90

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

4.b. continued

Age	Number of Visits
0 through 2 years	6
3 through 11 years	18
12 through 20 years	18

Speech and/or hearing examinations are provided on the basis of two examinations per recipient per state fiscal year, except for ages 0 through 1 year of age for which only hearing examinations are covered.

(4) Dental services:

(a) The following is the Tennessee Medicaid approved schedule for dental screening examinations:

Age	Number of Visits
0 through 2 years	4
3 through 11 years	18
12 through 20 years	18

Dental screening examinations are provided once every 6 months per recipient per state fiscal year.

(b) Requests for dental services requiring prior approval shall include a complete plan of treatment including all procedures to be performed regardless of whether a specified procedure requires prior approval, charting of all procedures to be done, and full-mouth set of X-rays; however, when an emergency situation exists and the recipient has had full mouth X-rays or a panorex within the previous three fiscal years, bitewings and a periapical X-ray shall constitute sufficient X-rays.

TN No. 90-7A DATE/RECEIPT 6/26/91
SUPERSEDES DATE/APPROVED 9-23-91
TN No. 89-16 DATE/EFFECTIVE 4-1-90

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

4.b. continued

(c) The following list of services, to the extent they are covered by Medicaid, shall require prior approval from the Medicaid medical director, or a designated representative, in order for the services to be reimbursed by Medicaid:

1. Preventive periodontics, routine periodontal scaling, root planing, subgingival curettage per quadrant.

2. Pulpotomy on permanent teeth is limited to apexification only.

3. Root canals shall be limited to one per tooth, per recipient, per lifetime.

4. Porcelain to metal crowns, permanent anterior teeth only; when a tooth cannot be restored satisfactorily with a filling material; and, there must be evidence of tooth maturity.

5. Space maintainers; approval for which shall be limited to fixed unilateral band type, fixed lingual or palatal arch band type (to be approved only when tooth adjacent does not require a stainless steel crown), and fixed band type with crown included.

6. Oral surgery, approval for which shall be limited to routine extractions of permanent teeth requiring prosthetic replacement, surgical extractions of primary or permanent teeth with complicating factors, treatment of soft tissue impaction, partial impaction or complete bony impaction root recovery (removal of residual root), and periodontal surgery where there are related medical factors.

7. Complete dentures and partial dentures with acrylic bases, without clasps or with wrought wire clasps or with cast clasps and lingual or palatal strengthening bar, and unilateral or one tooth partial plate with cast clasps and an acrylic base.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

4.b. continued

8. Non-conforming procedures or services.

9. Orthodontics, prior approval requests for which shall include, in addition to the requirements listed above for all prior approval requests, diagnostic models, an estimate of the total length of planned treatment not to exceed 24 months for orthodontic treatment and a schedule for monthly adjustments.

10. Hospitalization for dental services.

11. Prosthetic appliances which shall be limited to reconstruction in conjunction with previously completed oblative surgery primarily done in cases of cancer therapy and/or conjoint efforts at maxillofacial surgical reconstruction. Services must be rendered by a board certified prosthodontist.

12. Intravenous sedation for dental services given on an ambulatory basis for recipients with eetenuating physical or mental health problems. Approval will be granted only when sedation is administered by a dentist who is:

    a. Board eligible or board certified in oral and maxillofacial surgery; or

    b. Authorized by the Tennessee Board of Dentistry to use general anesthesia or intravenous sedation pursuant to T.C.A. 63-5-108(d) et seq. of the Board of Dentistry.

(d) Routine services not requiring prior approval are:

1. Routine examinations; bitewing x-rays, oral prophylaxis, and application of fluoride once every six months, per recipient;

2. Panographic or full-mouth x-rays limited to one set per three (3) fiscal years, per recipient;